



## Health Risk Assessment

**Health Risk:** *Case Manager should ask over the last 2 weeks, how often have you been bothered by any of the following problems?*

Question	Not at all	Several days	More than half the day	Nearly everyday
Little interest or pleasure in doing things?				
Feeling down, depressed, or hapless				
Trouble falling or staying asleep?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure and have let your family down?				
Trouble concentrating?				
Moving or speaking slowly or being to get fidgety or restless?				
Thoughts that you would be better off dead or of hurting yourself in some way?				

*If indication of Health Risk What action did you take:*

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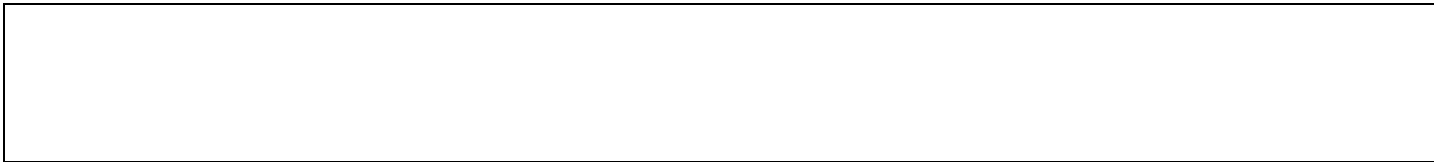
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*Additional Comments:*



## Services

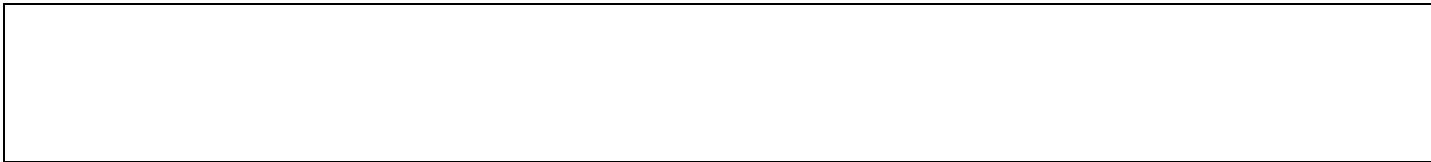
**Services:** *Check services the participant is receiving, describe the service satisfaction and that the Case Manager has verified that service provider has provided the service on the plan*

Area Assessed	Indicate the level of the participant's satisfaction with each waiver services using the following: E= Excellent S= Satisfactory P= Poor	Additional Comments	Check if Case Manager has verified that service provider has provided the services on the Care Plan for the month	How was this verified?
Case Management				
Personal Care Attendant				
Respite Care				
Home Delivered Meals				
Lifeline Installation				
Lifeline Monthly				
Non-Medical Transportation				
Adult Day Care				
Skilled Nursing				
Direct Services Worker				
Fiscal Management				

*Please check all that apply:*

Nurse Supervision Documented – Yes ☐ No ☐ PERS Unit physically checked that it is working properly Yes ☐ No ☐  
 Direct Service Worker Logs and Timesheets checked by case manager Yes ☐ No ☐

*Additional Comments:*



## Visit Outcomes

*Case Manager should Review the following (Check Y-Yes or N-No)*

	Y	N
APS information provided/reviewed		
Other Medicaid services needed		
Other Medicaid services referral made		
Other non Medicaid services needed		
Other non Medicaid services referral made		
Safety Planning reviewed		
Incident or critical event occurred		
Change in Plan needed		

*If Answered Yes to any of the above explain what action was taken:*

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*Additional Comments:*

## Additional Comments

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Participant/POA/Authorized Representative Signature (required)/Date

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Case Manager Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant/POA/Authorized Representative Printed (required)

\_\_\_\_\_  
Case Manager Printed